EXHIBIT 53

IN THE UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF OHIO
EASTERN DIVISION

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IN RE: NATIONAL PRESCRIPTION OPIATE LITIGATION

MDL No. 2804

Case No. 17-md-2804

Judge Dan Aaron Polster

This document relates to:

The County of Summit, Ohio v. Purdue Pharma L.P., et al.

Case No. 18-OP-45090

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Videotaped deposition of
LISA KOHLER, M.D.

July 31, 2018
9:15 a.m.

Taken at:
Brennan Manna & Diamond
75 East Market Street
Akron, Ohio

Renee L. Pellegrino, RPR, CLR

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to this. That is kept in a separate file and not in the case file.
Q. Do you know what was searched for and produced in this litigation?
A. Specifically, no.
Q. Do you know if all those different areas were searched for?
A. I do not know.
Q. And prior to 2015, or 2015 and prior, this was mostly paper?
A. Yes. It was largely -- well, we have the electronic version or the final version of the autopsy report. I don't recall the year that we started saving those electronically, but it's definitely -- as I mentioned, the paper versions are there and we have them in our office going back many years.
Q. How many years?
A. I do not know exactly at this time. I would have to go back and look.
Q. Ten?
A. At least a decade, but I don't recall an exact number of years.
Q. And do you know if those have been searched and produced?

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A. I know that based upon printouts similar to this, any of the drug overdose cases have been produced.
Q. But what about the underlying records that are in the paper form?
A. Those were produced.
Q. Okay. So let's just use this one as an example, if we could. Is it fair to say that if we discussed the process for 56510, it's going to be applicable to all of these others?
A. Yes. It's 54510, but yes.
Q. I'm sorry. I need to put my glasses on, I think. You can correct me if I read it wrong.
So this information, as you said, would be acquired from multiple sources, including an investigation, probably records that could have been found at the house, a driver's license, maybe talking to a family member as well as talking to healthcare providers and others who might have information about this individual; is that fair?
A. Yes, sir.
Q. And then we have a cause of death. Do you see that? It's in the --

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A. Yes.
Q. And this one says, "Doxepin overdose"?
A. Yes,sir.
Q. And then next to it, it says that there's doxepin and nordoxepin?
A. Correct.
Q. And it has amounts, I take it, that were found in that decedent?
A. Yes, sir.
Q. And is that the main way that -- I'm sorry. Toxicology results in connection with drug overdoses, is that a primary way of determining the cause of death?
MR. McCONNELL: Objection.
A. Could you rephrase that, please?
Q. Sure.
Well, I mean, the cause of death is listed as doxepin overdose?
A. Yes.
Q. And then the tox results show that there's doxepin and nordoxepin?
A. Correct.
Q. Let me ask you maybe a better question. How is it that you -- a determination

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is made about the cause of death?
A. The determination of the cause of death is made based upon the investigation, the autopsy examination and the testing results, in this case the toxicology. All of that is taken together, evaluated, and a cause and manner of death are ascribed to the case at that time.
Q. In this case the manner is suicide?
A. Yes, sir.
Q. There are multiple, I guess, manners that a doctor or investigator could assign, right?
A. The physician assigns it, yes.
Q. So what would lead someone to make a manner suicide?
A. There are multiple indicators that we would look at for a suicide death. We would look to see intent to cause self-harm. That can show up in many forms. It could be that when my investigator arrived at the scene, there was a farewell note out at the scene. It could be that they have laid out their funeral clothing. There could be a farewell note in the form of a voice mail message, an e-mail, some sort of digital message along those lines. In some

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cases it's the quantity of drug in their system that speaks for itself, that it was -- would not be where someone said, "To work, let's take three or four." This is the result of a handful of pills being taken at one time, showing that they intended to cause self-harm.
Q. Is it fair to say that this determination is not a precise science, it's more of a compilation of information and a judgment call?
A. Yes, it is an opinion. It's a medical opinion as to the manner of death.
Q. And I take it you would freely admit that many or some of these could be wrong, right?
MR. McCONNELL: I'll object.
A. Based upon the information that was provided to us at the time, we support the manners of death that are listed here. If additional information becomes available at a later date, we do review cases and can amend death certificates at that time based on the new information. But based upon the information provided to us at the time the assessment was made, we would believe that all of these are

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correct.
Q. Sure. I wasn't implying that anyone would intentionally put something wrong, but, for example, someone could intend to commit suicide without any indicia, right, no note, no laying out their clothes, no voice mails, and without that, they may just be classified as an accident, unless you had something else that was an outward indicia?
A. Right. And, actually, with a drug overdose, we favor accidental death as opposed to suicide unless we have some sort of indication that it was an intent to cause self-harm.
Q. So if in doubt, accidental death, unless you have something that would substantiate a suicide?
A. With regards to overdose, yes.
Q. Now, have you looked at this prior to today?
A. I have scanned it in the past. I do not know details of it.
Q. If you look at the last page, there's a tally of 213. Do you see that?
A. Yes, sir.

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Q. So am I correct that this is a collection of the overdose deaths that were processed by your department in the calendar year 2015?
A. Based upon how the database provided that information, yes, there were 213 overdose deaths between January 1 of 2015 and December 31st of 2015.
Q. And you're free to look through this, and I'm not going to ask you percentages, but would you agree, if I flipped through these and looked at each entry, the vast majority of them are through fentanyl or heroin deaths? Is that consistent with your understanding?
MR. McCONNELL: I'll object.
A. In the deaths where drugs are specifically mentioned in the cause of death statement, heroin and fentanyl are very well represented. I can't give you a percentage.
Q. And based on your experience, when it lists fentanyl, that's more likely or most likely to be illicit fentanyl; isn't that right?
MR. McCONNELL: I'll object.
A. It depends upon the year in which you are looking as to the likelihood of illicit

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versus prescription.
Q. Well, let's talk about 2015.
A. I can't tell from what is here whether it's illicit versus prescription, but it's been the trend in the recent years that it is illicit fentanyl.
Q. So let's start with this document. Are you able to differentiate between illicit fentanyl or any other type of fentanyl from looking at this document?
A. From this document, no.
Q. Do you have basic expertise in learning and other information from your experience that in 2015 illicit fentanyl was a significant, if not very substantial driver of the overdose deaths in your county?
MR. McCONNELL: Objection.
A. With regard to the fentanyl specifically, we will check OARRS to see if they have a prescription source of fentanyl before we will state that it is illicit. That was something that was a common practice in 2015, was to check OARRS for a prescription source. I don't have anything here to indicate which cases would be illicit versus prescription, but the

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general trend over the previous years has been that it is illicit.
Q. So if we wanted to actually know -- if it says -- let's take the second one. It says, "Accident drug overdose, fentanyl overdose," and there's "fentanyl 9.4 nanograms per millimeter"?
A. I'm sorry. Which one are you looking at?
Q. I'm sorry, Doctor. The second one. Sorry. Let me apologize. Let me find one that's easy here or easier. If you go to -- I'm trying to find one that just has fentanyl. Let's look at the second -- the second one on the first page. So this basically has fentanyl and morphine. Do you see that?
A. Yes, sir.
Q. It says "morphine," in parentheses, "free." What does that mean?
A. My toxicologist would differentiate between free and bound. He reports out free morphine.
Q. And what's the significance to a layperson?
A. You would need to talk with my

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toxicologist for that.
Q. Okay. And does it have any indication about whether it's a prescription medicine or illicit medicine?
A. Without pulling the file and looking through it, I can't comment as to whether this is fentanyl and heroin as a source of morphine or whether it is morphine on its own.
Q. I see. So the morphine -- actually, when it's listed as free or it's not listed as free, the morphine could actually be indicating that it's heroin?
A. Yes, sir.
Q. Because that's how it might show up on a tox screen?
A. In the blood heroin shows up as morphine. We need to look in the urine to find the 6-monoacetylmorphine to indicate it's a heroin source.
Q. And is that something that you do?
A. Yes, sir.
Q. And so that would mean that when it says "morphine," we could in some other records figure out if that, in fact, is someone who has either taken or abused morphine or whether the

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morphine is showing up because it was actually from illegal heroin?
MR. McCONNELL: Objection.
A. We could determine if there are markers for the use of heroin or not and then we're left with is it morphine from either morphine itself or that we are unable to substantiate that it's heroin or that we can substantiate that it's heroin, and that goes, again, into the investigation as well.
Q. And if we were to take this particular case, the second case, 54514, using some other tox data, we would be able to combine that with this chart and determine, based on the urine or some other testing, whether the morphine was more likely from heroin or from morphine; is that right?
A. Yes, sir.
Q. And with respect to fentanyl, could we also do the same; could we determine in some way whether it was illicit fentanyl or prescription fentanyl?
A. That would require that we look on the OARRS report to see if this person was prescribed fentanyl or not, and I don't know if

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in each individual case that we make a specific statement that OARRS was checked, but that is a part of the protocol to look.
Q. In 2015 that was part of your protocol?
A. Yes, sir.
Q. And so there would be some document contained somewhere in your department or a database or on paper that would show whether there was OARRS data, and if there was no OARRS data showing if there was a lawful prescription for fentanyl, the assumption would be it's illicit fentanyl; is that right?
MR. McCONNELL: I'll object.
A. The paperwork for OARRS may or may not be in the file. We are not permitted to keep that for an extended period of time. And I know in my practice many times I am looking it up and making a notation rather than printing out the OARRS report.
Q. Fair enough. But the point was at the time -- or you could go back and check and make that determination whether it was more likely to be illicit fentanyl or prescription fentanyl by looking at the OARRS data and using

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that data to make a considered judgment?
A. Yes. At the time we made the ruling, we would have looked, yes.
Q. And whether the actual documents or your notations were just left, that would be somewhere in files or paperwork at your department?
A. Yes.
Q. And based, again, just as a general matter, right, in 2015 do you have a general understanding of fentanyl overdoses, what percentage are from illicit fentanyl versus prescription fentanyl?
A. In general the illicit fentanyl is more frequent than prescription fentanyl.
Q. Ninety percent?
A. I cannot give a number.
Q. And even when we talk about -- there's a further description, right? There's illicit fentanyl, which is fentanyl that was created, prepared somewhere, that never had a pharmaceutical use, right?
A. Yes, there is illicit that was not meant for pharmaceutical use.
Q. And on the other hand, there is --

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fentanyl can be used, you know, in an approved medicine prescribed by a doctor, right?
A. Yes, sir.
Q. And then there's situations where someone could have a prescription fentanyl product but it's actually unlawful because it wasn't prescribed for them and they somehow are abusing it; is that right?
A. Yes, sir.
Q. So certainly I suspect you wouldn't know these answers right now, but do you believe that in 2015 or 2016, or even your current cases, you would be able to answer questions such as whether a person was prescribed a lawful opioid medicine at some point in the future -- at some point in the past?
A. Could you rephrase that?
Q. Sure.
Can you -- can you tell by looking at any of this information or -- whether someone had been ever prescribed a lawful opioid?
A. I can't know their full history because we don't necessarily ask for their entire life's history of opiate use.
Q. And you -- but, again, these are the

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kind of questions that, if you wanted to, you could go and talk to a doctor for any one of these folks and ask questions like, Did you ever prescribe an opioid for this patient, right?
MR. McCONNELL: Objection.
A. If we know the physician who was treating the patient, we can request information on what medications were prescribed to this patient. We do not always know the full lineage of physicians that this patient has seen and we may not have any information towards physicians they were seeing.
Q. But if you have it, you could do that, right? In fact, you do do it?
A. We will make requests, but, again, we don't ask for their entire life's history of opiate prescription. We're looking to the relevance to the cause and manner of death.
Q. Not entire life history. If you had a doctor's name, you could go -- and, in fact, it's your protocol to go to the doctor and ask some basic questions about the patient, what medicines they're taking, whether they had any illnesses, right, what other medicines they might have been using, whether they had

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depression, correct?
A. We will be asking for typically the most recent progress notes for that -- from that patient, their list of medications, and their problem list. That would be the information we would gather.
Q. And that would typically -- in most doctors' notes it would have medicines that the doctor prescribed, right?
A. Yes. That would be the medication list.
Q. And I think as you said, probably if we were to go back and look at all of the information that's currently in your office, to the extent it wasn't shredded, that information would still be there for some of the doctors you contacted, right?
MR. McCONNELL: I'll object.
A. The information that is in the file currently will still be there, yes.
Q. And some of that would have prescription medicine information, the notes you're talking about?
A. Yes, sir.
Q. I think you told us, and maybe

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there in 2006 is much more potent than it was in 1970 and it is very inexpensive relative to what it was in 1970.
Q. And then if you flip to "Prescription Drugs" -- do you see that?
A. Yes, sir.
Q. It says, "67 narcotic pills for each citizen of Ohio"?
A. Yes, sir.
Q. Is this data that you have independent knowledge of or is this information that you pulled from other sources to assist in your presentation?
A. This was pulled from other sources.
Q. Would you agree with me that you were not necessarily an expert on these areas, you were just trying to compile some information?
MR. McCONNELL: Objection.
Q. Or are you an expert?
A. I would consider myself, as a forensic pathologist, an expert in determining drug abuse deaths. In the situation for what we have here, this is information that was put out by a source here at Ohio, and I don't recall

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that source, that there were 67 narcotic pills prescribed for each man, woman and child in the State of Ohio in the year that this data was collected. And I don't recall that at this time. So this is information that was available through the internet and through other sources in describing what was going on with the opiate problem in the State of Ohio.
Q. Though we know from what you wrote in your note and what we've seen in these documents that, I think your word was, the vast majority of opioid deaths don't relate to narcotic pills to the extent at least they're prescriptions, right?
MR. McCONNELL: Objection.
A. Currently the vast majority of the deaths that I see are for illicit drugs. I do not know if there was a role played with prescription drugs earlier in the life cycle of that individual or not, but at the time that they are dying, the drugs they are dying from are illicit rather than the prescription drugs.
Q. And if you wanted to find out if there was a role, you would go do what you talked about, go and talk to their doctors, look

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at their medical records, and then you might have some more information to make that determination?
A. Yes. We may determine that this person had prescription opiates in the past, had exposures there, or they may not have.
Q. But without doing the digging, it's guessing, right?
MR. McCONNELL: Objection.
A. It's unknown if we haven't asked the question or the information is not available. We assess cause and manner of death based on what is going on at the time a person dies.
Q. And then the rest of this, kids raid drug cabinet, Skittles parties, is this just taking about children who are using -- kids who are using medicines that they find in their parents' or friends' houses and then taking them for supposed recreational use?
A. Yes, sir.
Q. The next page, "Prescription Drug Medicines," do you see that?
A. Yes, sir. "Prescription pain medications"?
Q. Yes. I'm sorry. Thank you, Doctor.

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Can you just tell us, how would you present this slide?
A. Just making people aware that if you have prescription medications in your home, to make sure that they are not easily accessible to teens. Going back to the previous slide we just talked about, children had the ability to go into their parents' medicine cabinets and take medications that were not prescribed to them, so be aware that that's a practice. It's difficult for the addiction potential to know is this all nature versus nurture and environment. And that it has been called an epidemic. In 2012, 24 percent of teens used prescription drugs without a prescription. And that's data that was pulled from another source, but I don't recall at the time.
Q. And what do you mean or what does this slide -- or how would you present this nature versus nurture/environment?
A. At the time when I'm presenting this, there were debates is this something that is organic in that individual that caused them to become a drug addict or is it being placed into an environment where these drugs are

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readily available and they have the opportunity to try them. So it's a question of which is the more -- the greater source of the cause for addiction.
Q. And that specifically, the answer to that question or examining that, that's outside your expertise?
A. Correct.
Q. You were just reporting on the nature of the dialogue at the time?
A. Yes, sir.
Q. The next slide, do you know where you got those statistics from in that little pie chart on the top?
A. I don't recall the source of that pie chart. The bottom chart also does not have the location.
Q. According to the pie chart, people who abuse prescription painkillers get drugs from a variety of the sources, right?
A. Yes.
Q. And it looks like 58 percent, is that right, or is that 56 percent?
A. 55 percent obtained free from friend or relative.

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Q. Thank you.
And then 17.3 percent are prescribed by one doctor?
A. Correct.
Q. So am I reading this correctly to say that basically other than 17.3 percent, all of the others -- other than 17.3 percent who are prescribed by a doctor, all of the others who abuse prescriptions, according to this chart, get the drugs from illegal or unlawful places?
MR. McCONNELL: Objection.
A. There is 7.1 percent that say other source. I don't know if they're getting it from more than one physician or how that is broken down, but it does state that 17.3 percent were prescribed by one doctor, and the other categories other than the other source indicate that they're getting it from a drug dealer, stranger or a friend or relative.
Q. The next slide looks like a screenshot of some sort.
A. Yes.
Q. It says, "Contributing Factors"?
A. Yes, sir.
Q. Do you know where you got this from?

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A. I don't recall at this time.
Q. Do you recall enough about this to tell us what you would -- how you would have presented this?
A. Just showing that there are multiple factors that are contributing to the opioid epidemic, the central circle showing increased exposure, increased substance abuse, and going on into the epidemic. And the outer boxes are showing different habits or activities that are believed to have contributed to this epidemic.
Q. So is the point there's no one cause, there's all these different various multiples -- multiple influences that lead to ultimately the epidemic?
A. Yes. It's a multifactorial problem.
Q. And then if you flip to another page, Doctor, it's the colorful "Annual Summit County Overdose Deaths." Do you see that?
A. Yes, sir.
Q. Can you tell us what this represents? The reason why I ask, Doctor, to the extent your memory reflects it, I wasn't clear kind of how the total overdose deaths broke out with the various four other

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categories, whether it was overlapping. Do you have a recollection, because the numbers didn't seem to add up for me at least?
A. There is overdose -- or overlap here. We've got just the general total overdoses in that first group of multi-colored columns. The heroin has shown an increase over time. I don't recall if -- what the illicit only refers to. I would have to go back and look at those numbers and compare them to the stats. There is a group that is both combination of illicit drugs as well as prescription. And when you look at the prescription only or Rx only, those numbers have been decreasing over the four-year time frame that I was sampling there. So in the time frame that heroin is increasing, prescription drugs are decreasing.
Q. And that's what your little note says right on the side, not your little -- that's what your note says, prescription drug deaths decreasing, heroin deaths increasing?
A. Yes, sir.
Q. And if you flip the page, "Drug Abuse Trends in Summit County"?

A. Yes, sir.
Q. So in 2014, 144 overdose deaths for the year; of that, 34 were heroin, 45 Fentanyl, and combined were 19?
A. Yes, sir.
Q. And then in 2015 -- so this must have been done at least after -- sometime after September 2015 is when you presented this?
A. Agreed.
Q. Heroin had dropped 25 percent, fentanyl deaths had risen 72 percent?
A. 60 percent.
Q. I'm sorry. Had risen to 60 percent. Thank you. And the combined use of heroin and fentanyl were up, right?
A. Yes, sir.
Q. And in this time frame is it fair to say that your belief and understanding in the 2014-15 period, that the fentanyl deaths that are referenced here were -- the vast majority were illicit fentanyl?
A. I believe so, yes.
- - - - -
(Thereupon, Deposition Exhibit 8, Article Entitled "Carfentanil and

Current Opioid Trends in Summit County, Ohio," was marked for purposes of identification.)
- - - - -
Q. I'm going to show you in a minute what we're marking Exhibit 8, an article called "Carfentanil and Current Opioid Trends in Summit County, Ohio." It's one that you were an author on.
Can you tell us the circumstances of why you and your colleagues or your co-workers got together and decided to publish this?
A. I believe that was co-authored by Kristy Waite. Is that correct?
Q. It was. And I'm going to show it to you in a second. We got it here. So I've given you -- this is Exhibit -- what does it say, Doctor?
A. 8.
Q. Are you familiar with this article?
A. Yes, sir.
Q. Is this -- is it a peer-reviewed article, if you know?
A. I don't recall if this is a peer-reviewed publication or not.

Q. Are all of these -- what's your relation to Ms. -- I don't know if they're doctors. I'll call them Ms. Waite, Ms. Deeken, Mr. Perch and obviously you. Who are those people?
A. Dr. Waite at the time was a pathology resident at Summa Health System and she had rotated through our office previously. She has aspirations of becoming a forensic pathologist and is currently completing her forensic fellowship.
Amy Deeken is also Dr. Deeken. She is a member of the staff at Summa in the pathology department. She was basically Dr. Waite's supervisor. Because Dr. Waite had aspirations to become a forensic pathologist, as she is currently doing, she wanted to have an opportunity to publish in the forensic field, and between myself, Dr. Waite and Dr. Deeken, this topic was chosen because it was contemporaneous to what was going on in our office with the increase in the carfentanil and we felt that this was a good topic for her to pursue.
And then Mr. Perch is my

toxicologist and he assisted Dr. Waite in understanding his portion of the contribution to this article.
Q. Can you give us kind of a summary of what you saw and how this issue came about?
A. Could you be more specific in your question?
Q. Sure. I'll tell you how I think it's summarized and you tell me if you agree with it.
A. Okay.
Q. So at some point you saw an increase in overdose deaths and you ultimately were able to attribute it to carfentanil and developed methods to test for carfentanil that were not previously obvious to you and perhaps others in the community and you wrote this piece to tell them about your learning so others might benefit from that?
A. To some degree that's accurate. The carfentanil issues began in our community the July 4th weekend of 2016 and skyrocketed through the rest of 2016. This is a drug that we had not seen in our community prior to July 4th weekend of that year. At that time we did not

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have a method to identify it, and Mr. Perch was able to develop a method so that we could begin to identify it and worked with other toxicology people within the -- within the state to help develop methods that would be reliable for identifying this.

And there were other communities throughout the United States that were not seeing carfentanil at all, so we felt that it was important they be aware of the fact that this is a drug out there that they may not be looking for, and because they're not looking for it, would not detect it, and that the detection required special instrumentation to perform.

Q. So just to make sure, you know, the record and everyone is on the same page, my understanding -- tell me if this is right, Doctor -- carfentanil is used literally as an elephant tranquilizer, a large animal tranquilizer, right?

A. Yes, sir.

Q. It's not supposed to be used for people?

A. There's no clinical application in humans.

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Q. In fact, I've seen information that it's like 10,000 times more powerful than other prescription type pain relievers?

A. Yes. It is significantly more powerful.

Q. And you saw a spike in July 2016, but because there was no testing methodology at least in Summit, you don't really know or can't tell whether some of the previous overdose deaths had carfentanil involved; is that fair?

MR. McCONNELL: I'm going to object.

A. I believe that once we came up with the testing, we did look back at some of the cases. I don't recall the details of that.

Q. Do you know how far back you looked?

A. It would just be in the previous months, if I recall correctly, but that would be a question for Mr. Perch.

Q. So if it was the previous months, assuming that was the case, we could ask Mr. Perch, but then it wouldn't get us anything prior to -- 2015 or prior to that?

A. Correct.

Q. And obviously to the extent that you're unable to test for it, you're unable to

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make a determination whether, in fact, it was a causative factor?

A. Correct.

Q. But when it essentially became detected and had its very significant adverse consequences on the community, according to your article, there were a spike of 35 deaths in both July and August, right? And I'm on the third paragraph of your -- the results.

A. Yes, sir.

Q. So that's 70 people?

A. Yes.

Q. And then it decreased to 12 deaths in December?

A. Yes, sir.

Q. And am I correct that there were also -- in September, October and November there were likely additional deaths from carfentanil?

A. I would have to look at our statistics to know how many were present in those months.

Q. So even if we were to not talk about those, just in the statistics you have here, it looks like there would be 82 deaths, right?

A. Yes, sir.

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Q. So that spike would, when you look year over year, if we saw an increase from 2015 to 2016, we would want to account that at least 80, if not more of those, were the result of this, essentially, carfentanil spike?

A. Okay. Could you restate that question?

Q. Sure. Sorry.

Prior -- you're unaware of whether there was -- let me strike that.

Do you know if there continued to be carfentanil related or caused deaths into 2017 and '18?

A. Yes, sir.

Q. You still see them?

A. Yes, sir.

Q. Is this an area, this carfentanil death and other fentanyl analogs, where you're working with law enforcement?

A. We work with law enforcement on a regular basis. I'm not sure what you are asking specifically.

Q. After seeing basically 80 or more people die in six months in 2016, did you do anything above and beyond your normal practices